accordance with rule 5101:3-2-0713 of the Administrative Code.

Effective Date: 2/1/00

Rule Review: _____

Certification: _____

_____
Date

Promulgated Under RC Chapter 119.

Statutory Authority RC Section 5111.02

Rule Amplifies RC Sections 5111.01 and 5111.02

Prior Effective Dates: 10/1/84, 7/29/85, 7/3/86, 10/19/87, 7/1/89, 1/1/91, 9/3/91 (Emer.), 11/10/91, 7/1/92, 4/1/93, 8/1/93

5101:3-2-072 Classification of hospitals.

For purposes of setting rates and making payments under the DRG prospective payment system, the department classifies most hospitals into mutually exclusive peer groups.

(A) Definitions.

(1) "Teaching hospitals" are hospitals with major teaching emphasis that meet one of the following definitions: the hospital, regardless of number of beds has an intern- and resident-to-bed ratio of at least .35 or the hospital has greater than five hundred beds and has an intern- and resident-to-bed ratio of .25. For purposes of this paragraph, the intern- and resident-to-bed ratio for Ohio hospitals is that recognized by the hospital's medicare fiscal intermediary for the hospital's cost-reporting period described in paragraph (D) of rule 5101:3-2-074 of the Administrative Code. For non-Ohio hospitals, the intern- and resident-to-bed ratio used to make this determination is derived from the medicare cost report for the cost-reporting period used in setting rates for rate period beginning July 1, 1990.

(2) "Children's hospitals" are those hospitals that primarily serve patients eighteen years of age and younger and that are excluded from medicare prospective payment in accordance with 42 CFR 412.23(d).

(3) "Rural referral center hospitals" are those hospitals located in non-MSA areas which are recognized by medicare as rural referral centers in accordance with 42 CFR 412.96.

(4) "MSA-area hospitals" are those hospitals not defined in this rule as children's or teaching hospitals that are located in metropolitan statistical areas (MSAs) as those areas are established by the federal office of management and budget.

(5) "Non-MSA area hospitals" are those hospitals not defined in this rule as teaching, children's, or rural referral centers that are not located in metropolitan statistical areas (MSAs) as those areas are established by the federal office of management and budget.

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(6) "Cancer hospitals" are hospitals recognized by medicare which primarily treat neoplastic disease in accordance with 42 CFR 412.23(F).

(7) For the purposes of this rule, the "number of beds" is the total number of beds reported in the December, 1986 "Directory of Registered Hospitals" published by the Ohio department of health.

(B) Ohio hospital prospective payment peer groups.

(1) For each Ohio children's hospital, a prospective rate will be determined in accordance with rule 5101:3-2-074 of the Administrative Code using data which is specific to each hospital.

(2) Rural referral center hospitals are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-074 of the Administrative Code using data from these hospitals.

(3) Teaching hospitals are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-074 of the Administrative Code using data from these hospitals.

(4) Non-MSA area hospitals with less than one hundred beds are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-074 of the Administrative Code using data from these hospitals.

(5) Non-MSA area hospitals with one hundred beds or more are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-074 of the Administrative Code using data from these hospitals.

(6) MSA-area hospitals are peer grouped on the basis of wage index categories. MSA-area hospitals that have adjusted gross wage index categories in their area, as published in the March 1985 "Report on Hospital Wage Index" required by section 2316(a) of Public Law 98-369 within .01 (rounded values) of each other are grouped together for payment purposes. For each of the groups formed, a peer group average cost per discharge is developed in accordance with rule 5101:3-2-074 of the Administrative Code using data from hospitals in the group.

(C) Non-Ohio prospective payment peer groups.

(1) For discharges on or after July 1, 1990, non-Ohio teaching hospitals will be reimbursed on the basis of a rate developed using data from Ohio teaching hospitals. The calculations used to develop this rate are described in paragraphs (C)(1)(a) to (C)(1)(b) of this rule.

(a) For each Ohio teaching hospital a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(a) of rule 5101:3-2-074 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-074 of the Administrative Code is not made.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(1)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-074 of the Administrative Code. The results of these computations are summed for all Ohio teaching hospitals, and then divided by the sum of medicaid discharges for all Ohio teaching hospitals. The result of this computation is rounded to the nearest whole penny.

(2) For discharges on or after July 1, 1990, non-Ohio children's hospitals will be reimbursed on the basis of a rate developed using data from Ohio childrens hospitals. The calculations used to develop this rate are described in paragraph (C)(2)(a) to (C)(2)(b) of this rule.

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(a) For each Ohio children's hospital a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(b) of rule 5101:3-2-074 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-074 of the Administrative Code is not made and except that the value of .12 is substituted for the value calculated in paragraph (F)(2)(e)(ii) of rule 5101:3-2-074 of the Administrative Code.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(2)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-074 of the Administrative Code. The results of these computations are summed for all Ohio children's hospitals, and then divided by the sum of medicaid discharges for all Ohio children's hospitals. The result of this computation is rounded to the nearest whole penny.

(3) For discharges on or after July 1, 1990, non-Ohio hospitals that are not teaching or children's hospitals will be reimbursed on the basis of a rate developed using data from Ohio nonteaching and nonchildren's hospitals. The calculations used to develop this rate are described in paragraph (C)(3)(a) to (C)(3)(b) of this rule.

(a) For each Ohio nonchildren's and nonteaching hospital, a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(a) of rule 5101:3-2-074 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-074 of the Administrative Code is not made.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(3)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-074 of the Administrative Code. The results of these computations are summed for all Ohio nonteaching and nonchildrens hospitals, and then divided by the sum of medicaid discharges for all Ohio nonteaching and nonchildrens hospitals. The result of this computation is rounded to the nearest whole penny.

(D) Classification procedures.

(1) A hospital is classified into a peer group at the beginning of each rate year based upon the data available to the department sixty days prior to the rate year. Once established, the classification of a hospital into a peer group remains in effect throughout the rate year unless the hospital is designated by medicare during the rate year to be a rural referral center hospital. In this instance the hospital must submit all documentation to the department that it has been designated as a rural referral center. After such documentation is received, the hospital will be reclassified into the rural referral center peer group effective for discharges occurring on or after the beginning of the rate year or the effective date of the designation, whichever is later.

(2) When an existing hospital is deleted or added to a peer group at a time other than when the department rebases the DRG system, the deletion or addition of a hospital from a peer group does not result in a redetermination of payment rates for the peer group except as otherwise provided in rule 5101:3-2-078 of the Administrative Code. If a new hospital is established at a time other than when the department rebases the DRG system, the department will assign that hospital to a peer group for payment purposes but will not recalculate any part of the prospective payment rate for that peer group. In the case of cancer hospitals, as defined in this rule, that are established at a time other than rebasing of the DRG system, the cancer hospital will receive the same prospective payment rate in all respects as the

major teaching hospital that is located in the same metropolitan statistical area. UNTIL A COST REPORT FOR THE HOSPITAL HAS BEEN SUBMITTED IN ACCORDANCE WITH RULE 5101:3-2-23 OF THE ADMINISTRATIVE CODE. UPON REVIEW OF SUBMITTED COST REPORT, THE DEPARTMENT MAY REDETERMINE THE REIMBURSEMENT METHODOLOGY FOR THE CANCER HOSPITAL.

(3) Facilities which close at a time other than rebasing of the DRG system and that notify the department of closure thirty days prior to the beginning of a rate year are not included in the peer groups defined in this rule for the purpose of setting payment rates. Closure notifications received less than thirty days prior to a rate year do not result in a redetermination of peer group payment rates for that year.

(4) In the case of hospital mergers when all facilities involved in the merger retain separate provider numbers for the medicare program, each facility will be treated separately following the procedures outlined in this rule. In the case of hospital mergers when the merged facility retains only one medicare provider number, the department will either follow the determinations made by the medicare program with regard to treatment of the merged facilities or will make a separate determination. Such separate determinations will be made, on a case by case basis, in instances when medicare's determination would be appropriate in the context of medicare pricing and classification methods but inappropriate in the context of medicaid pricing methods and peer grouping logic as described in this rule.

5101:3-2-073 Methodology for determining relative weights.

(A) General description.

For hospitals subject to prospective payment for inpatient services, the department will reimburse for inpatient hospital services an amount per discharge in each diagnostic category. The payment is reflective of the relative hospital resources used by each diagnostic category in comparison to the statewide average resource use for an admission. The method for determining the weight of a diagnostic category is based on its average charge compared to an average charge for all discharges. This rule describes the diagnostic categories and the method for determining the relative weights for each category. Special consideration is given to psychiatric DRGs 425 to 435 ~~437~~ and neonatal DRGs 385 to 390 as described in this rule.

(B) Diagnostic related groupings.

(1) Except as otherwise specified in paragraph (E) ~~(F)~~ of this rule, relative weights are calculated for each classification of inpatient hospital discharge classified by "grouper," a software package distributed by, "3M Health Information Systems", used by medicare during federal fiscal year 1998 ~~1993~~ and modified as described in this rule. Services are classified into one of the diagnostic categories based on:

(a) The ICD-9-CM principal and secondary diagnoses;

(b) The ICD-9-CM surgical procedures provided to the recipient during a hospital stay;

(c) The recipient's sex;

(d) The recipient's age; and

(e) The recipient's discharge status.

(2) Cases which would be classified in DRG 385 or DRG 456 because of a transfer or death but which involve a length of stay greater than fifteen days are classified in the DRG which is appropriate in accordance with paragraphs (B)(1) to (B)(1)(e) of this rule if the transfer or death is not considered.

(3) For cases classified into DRG 386, three subgroups are identified and three different relative weights are calculated, based upon the ICD-9-CM codes and the level of the neonatal nursery. These levels are those recognized by the Ohio department of health as of March 29, 1987.

(a) One subgroup and relative weight is created based upon cases which have ICD-9-CM code 765.0 ~~7650~~ listed as one of its diagnoses.

(b) For cases which group as a DRG 386, and do not have ICD-9-CM code 765.0 ~~7650~~, two relative weights are calculated for this subgroup. One relative weight

is calculated using data specific to hospitals with a level I or II nursery and a second relative weight is calculated using data specific to hospitals with a level III nursery.

(4) For cases classified into DRG 387, four subgroups are identified and four different relative weights are calculated, based upon the infant's birthweight and the level of the neonatal nursery. These levels are those identified by the Ohio department of health as of March 29, 1987. These subgroups are described in paragraphs (B)(4)(a) and (B)(4)(b) of this rule.

(a) For cases which group into DRG 387 and have a birthweight of zero to one thousand seven hundred fifty grams, two subgroups are identified and two relative weights are calculated within each subgroup. One relative weight is calculated using data specific to hospitals with a level I or II nursery and a second relative weight is calculated using data specific to hospitals with a level III nursery.

(b) For cases which group into DRG 387 and have a birthweight of one thousand seven hundred fifty-one grams and above, two subgroups are identified and two relative weights are calculated within each subgroup. One relative weight is calculated using data specific to hospitals with a level I or II nursery and a second relative weight is calculated using data specific to hospitals with a level III nursery.

(C) Medicaid claim record.

For the purposes of determining the relative weight for each diagnostic category (DRG), the sample includes all claims associated with discharges on or after September 1, 1993 through June 30, 1995 and paid by June 30, 1996. All claims included in the sample were previously paid and passed through the edits created by the Ohio department of human services (ODHS) prospective payment system. ~~All claims except some heart transplants, liver transplants, and bone marrow transplants were previously grouped into a DRG and edited by the clinical editors for groupers used by medicare during federal fiscal year 1987, federal fiscal year 1989, federal fiscal year 1991, or federal fiscal year 1993 dependent on the date of discharge recorded on the claim. The "Clinical Editor" is a software package distributed by "3M Health Information Systems" which edits claims for clinical consistency and acceptable diagnosis and procedures codes.~~ Claims were adjusted as described in paragraphs (C)(1) to (C)(2)(b) of this rule.

(1) Claims deleted from computation.

(a) Claims that were submitted by an out-of-state provider

(b) Claims that were submitted by a hospital excluded from the prospective payment system as described in rule 5101:3-2-071 of the Administrative Code.

(c) Claims that were originally grouped into DRG 000, 469 or 470.

(d) When two or more records existed with the same provider, same recipient number, and exact dates of services, the latest paid claim was retained and the earlier paid claim or claims were deleted.

(e) If multiple claims for the same provider, same recipient number, and overlapping dates of service occurred, and the date span of the most recently paid claim included the date span of any and all overlap claims, and none of the claims grouped into DRGs 425 to 435, the most recently paid claim was retained and all others were deleted.

(f) Claims associated with cases that were incorrectly billed to ODHS, e.g., where third party covered the entire stay.

(g) Claims that were for an inpatient discharge but had charges of less than one hundred dollars, unless there were ten or fewer claims that grouped into the DRG.

(h) Transfer claims unless there were ten or fewer claims that grouped into the DRG

(i) Nontransfer claims paid on a per diem basis.

(j) CLAIMS WITH NET CHARGES EQUAL TO ZERO.

(2) Adjustments to claims.

(a) Claim-specific adjustments were included if processed by the Ohio department of human services by June 30, 1996.

(b) Organ acquisition and transportation costs for heart, liver and bone marrow transplants were removed from the claim prior to submission to the grouper.

(D) Development of the relative weights.

The relative weights were calculated based upon the total allowable charge for each case for the sample of claims as described in paragraphs (C) to (C)(2)(b) of this rule, subject to the edits as described in paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

(1) Computation of the geometric mean charge for each DRG.

(a) For DRGs 1 to 385, 391 to 424, 439 to 503 ~~490~~, the geometric mean charge was determined for each of these DRGs.